MADRAS MEDICAL COLLEGE AND

RESEARCH INSTITUTE

CHENNAI

PSYCHOLOGY CASE RECORD

Submitted to

The Tamilnadu Dr. M. G. R. Medical University

In Partial Fulfillment of the Requirements

for

DPM Final Examination

March 2010

By

Dr. S.VIDHYA LAKSHMI

INSTITUTE OF MENTAL HEALTH, KILPAUK

CHENNAI – 600 010

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BONAFIDE CERTIFICATE

This is to certify that this is a bonafide record of the work done by **Dr. Vidhya lakshmi** in partial fulfillment of the requirement for the DPM Final Examination of the Tamilnadu Dr. M. G. R. Medical University during the period June 2008 - March 2010.

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ACKNOWLEDGEMENT

I am very much grateful to the Dean, Madras Medical College, Chennai - 600003, who has given his kind permission to interview the patients for preparing this case record.

I thank the Director, Institute of Mental Health, Chennai - 600 010, who has given his kind permission to interview the patients for preparing this case record.

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I would also like to thank the patients and their family members who cooperated for undergoing the tests and gave the necessary details required.

INDEX

PATIENT I

Name	:	Ms. V
Age	:	24 yrs
Sex	:	Female
Occupation	:	Unemployed
Religion	:	Hindu
Education	:	B.Sc. discontinued
Socio economic	:	MSES
Informants	:	Self and mother
Information	:	Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

1. Low mood	3 months
2. Dull and withdrawn	
3. Easily irritable	
4. Sleep disturbance	
5. Loss of appetite and fatigue	
6. Suicidal attempt	2 weeks ago

IV episode, gradual in onset,

Precipitated by change of job,

I psychiatric consultation

HISTORY OF PRESENT ILLNESS:

Ms.V was reported to be normal 3 months ago, when she was noticed to be pre occupied and quieter than usual since changing job, looked dull and less communicative. She felt low most of the day, did not feel like doing anything, felt intensely tired and a distinct lack of interest in doing things she used to enjoy earlier. She kept worrying over minor matters and became annoyed and irritated at the slightest provocation. She did not enjoy the television programmes which she used to enjoy earlier. She had difficulty falling asleep and maintaining sleep – got up frequently during the night. She had loss of appetite. She felt giddy, tremulous, sweating at times when she went out. She had taken an over dosage of tablets 2 weeks ago following a quarrel at home.

No history of repetitive thoughts or acts.

No history of elated mood or boasting

No history of suspiciousness.

No history of hearing voices.

No history of substance abuse, head injury, seizures.

PAST HISTORY:

I episode – 8 yrs ago, precipitated by the death of her father, lasting 1 year characterised by low mood, being less communicative, confining to home, suggestive of depressive episode, improved spontaneously.

II episode – A period when she was generally cheerful, active, developed many new interests, very sociable, kept herself busy from morning to night, was energetic, needed less sleep than usual, lasting 3 months.

III episode – Precipitated by the breaking up of a love affair, characterized by low mood, crying spells, loss of interest, decreased activity, dull, withdrawn behavior and self-harm behavior, improved without treatment.

FAMILY HISTORY:

She is the 3rd of 4 children, born of non consanguinous marriage.

H/o alcohol dependence in father and paternal uncle both died due to physical complications of alcohol use.

H/o MR in maternal cousin. H/o Hypothyroidism in mother.

PERSONAL HISTORY:

Normal delivery. Nail biting since childhood. Discontinued B.Sc. in 3rd year.

Has worked as a saleswoman in various shops, as tailor, in marketing and as LIC agent.

Menstrual irregularity present. 3/45 days.

PREMORBID PERSONALITY:

She was shy, kept to herself, had very few friends, calm and quiet, attached to father and younger brother, was sensitive, not adjustable, religious, introvert.

PHYSICAL EXAMINATION:

Conscious, ambulant

Linear scars Left forearm.

BP – 110/70 mm Hg.

PR-80/min.

CVS – S1, S2 heard.

RS – NVBS heard.

Abdomen – Soft, nontender, No organomegaly

CNS – Clinically normal.

Fundus – normal.

MENTAL STATUS EXAMINATION:

General Appearance and Behavior:

The patient was well kempt, alert, took the seat offered, cooperative, Gaze contact was made and maintained. Rapport was established.

In touch with the surroundings.

Motor activity: Normal.

Talk: Relevant and coherent, Quantum, Tone, Rate- normal.

Reaction Time normal.

Mood : Dysthymic

Affect: Depressed, appropriate, reactivity-present, no lability.

Thought – Form, stream- normal, Content: Ideas of guilt and worthlessness, Ideas of hopelessness, depressive ruminations.

Perception – No perceptual disturbance.

OTHER COGNITIVE FUNCTIONS:

Consciousness: patient is alert.

Oriented to time, place and person.

Attention arousable, Concentration well sustained

Digit Forward – 5

Digit Backward – 4

Memory – immediate, recent and remote – intact

General fund of information – adequate

Average intelligence

Abstract thinking intact.

Judgement to test situation intact

Insight: Grade V.

INVESTIGATIONS:

Haemotological investigations – Normal

ECG – normal

EEG – normal

Thyroid profile – normal

Chest X-ray – NAD

PROVISIONAL DIAGNOSIS

ICD-10: F 31.30 Bipolar affective disorder, current episode moderate depression, without somatic symptoms.

PSYCHOMETRY:

Ms. V was assessed for her personality, psychopathology and diagnosis with rating scales and projective tests.

TESTS ADMINISTERED

Eysenck Personality Questionnaire was used to assess the different dimensions of her personality

Symptom Sign Inventory to assess symptom loading on various diagnostic categories.

Multiphasic Questionnaire – to assess her personality. Hamilton Rating Scale for Depression

Young Mania Rating Scale was used to rate intensity of various symptoms she was exhibiting.

Sentence Completion Test was used to elaborate on her attitude towards family, parents, and her interpersonal relationships.

Thematic Apperception Test, a projective test of personality used to assess her interpersonal relationship, goals and conflicts.

Rorschach test, a projective test of personality used to assess her personality structure and diagnosis.

State and Trait Anxiety Inventory – used to assess her anxiety levels.

BEHAVIORAL OBSERVATION:

Rapport was established. Attention could be aroused and sustained. Talk was relevant and coherent. She was able to comprehend the instructions. Crying spells were present in initial sessions.

TEST FINDINGS:

Personality and Interpersonal:

On Eysenck Personality Questionnaire, her lie scale is high. So, the protocol needs to be interpreted with caution. High on neurotic traits in her personality. State and Trait Anxiety scale shows a generalised trait anxiety is present in the patient and also high on state anxiety. Bell's Adjustment Inventory showed average home adjustment, average health adjustment, retiring in social adjustment, unsatisfactory in emotional adjustment with average occupational adjustment.

On Sentence completion test, she has an optimistic outlook about her future, poor motivation to overcome her problems and uncertainty about her future.

Thematic Apperception Test has shown there is a strong need for affection and belongingness. Stories have projected on guilt feelings, depressive feelings, pessimistic and insecure feelings, worried about her past. The main themes of the stories are based on worries, problems and family life.

On Symptom Sign Inventory, scores were significantly elevated on Anxiety scale, Depression scale and Paranoid scale. Hamilton Rating Scale for Depression has shown moderate amount of depressive feelings. The scores were not significant on Young Mania Rating Scale.

On Rorschach, total responses were 16 with average mentation time. Patient has given 7 popular responses, 9 originals with fluctuations in form level rating. Content analysis shows animals, humans, anatomical and decay.

IMPRESSION:

Patient with adequate cognitive functions with high on trait anxieties, poor adjustment on emotional area and social area with evidence of depression.

SUMMARY:

She has symptoms of moderate depression with features of anxiety on various tests indicating that the patient is suffering from mood disorder currently depression.

FINAL DIAGNOSIS:

ICD-10: F 31.30 Bipolar affective disorder, current episode moderate depression, without somatic symptoms.

MANAGEMENT:

PHARMACOLOGICAL

Patient is on C. Fluoxetine 20 mg 1-0-0

T. Propranolol 40 mg 1-0-0

T. Sodium Valproate 200 mg 1-1-1

PSYCHOLOGICAL

Cognitive Behavioural Therapy – to correct her cognitive distortions and negative schemas.

Activity scheduling was done.

Interpersonal psychotherapy to improve her social skills and adjustment with others.

PATIENT II

Name	:	Mr. J
Age	:	24 yrs
Sex	:	Male
Marital status	:	Unmarried
Occupation	:	Unemployed
Religion	:	Hindu
Education	:	X standard discontinued
Socio economic	:	LSES
Informants	:	Mother and self
Information	:	Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

Not going to job

Laughing , singing and dancing } past 11 months

Claiming that he is the world super star

Suspiciousness

Excessive Talk

Hearing god's voices } past 9 months

Abusive and assaultive

Sleep disturbance

Decreased self care ---------- past 3 months 10

Insidious onset, continuous, progressive, not associated with any stressor.

I consultation at IMH

HISTORY OF PRESENT ILLNESS:

Mr. J was reported to be normal 11 months ago working in his uncle's bakery and taking care of his family well. Suddenly one day he left his job and told his parents that he had plans to start a bakery on his own. His parents were not willing to support his plan and he abided by his parents words. He dropped his plan and went to a textile mill for job as his mother persuaded him. He worked only for 2 days a week , only on those days when he received signals from his deceased grandfather who came to their house in the form of a crow. In the mill, he was laughing, singing and dancing and was very energetic for about a month. He changed his job, went to another bakery for job for 3 weeks. Then he went as a security in a cycles and 2 wheeler stand and worked there for only a week. He started staying at home, singing and dancing and talking excessively, spontaneously to self and to parents. He told them that he was able to hear voices of goddess omshakthi and god narayanan telling him that he was going to inherit a huge sum of money and property, if he would marry his uncle's daughter. He told his mother that god asked him to act like a mad for a period of 1 year till he inherits the property. He started eating less and drinking lot of water. His sleep decreased , had frequent awakenings. He started claiming that he was world superstar Jackie chan and was going to start teashops throughout the world.

He started saying that people were talking ill of him. He was constantly muttering in his home. He also began to say that all were knowing his thoughts through the crow. His

personal hygiene deteriorated. He started spending money lavishly and excessively. This continued for about 4 months. He started staying in a separate room, carrying out his routine activities only when he had orders from god Allah. This continued for about 3 months. Then he started throwing stones at people and started running naked in the streets. So he was brought to IMH for treatment.

No history of persistent sadness/ crying spells

No history of repetitive thoughts or acts

No history of any vague fear / palpitations/ tremors

No history of any head injury/ LOC/ seizures

No history of substance use

PAST HISTORY:

No similar illness in the past.

No positive medical or surgical history.

FAMILY HISTORY:

H/o psychotic illness of long duration in maternal aunt.

H/O alcohol dependence in father.

PERSONAL HISTORY:

Full Term Normal Delivery. Developmental milestones normal.

Studied upto X standard, discontinued 10^{th} std. Last job was as a security in a cycle stand.

Alcohol use –2 occasions at his 24 years of age.

PERSONALITY TRAITS:

Liked being alone, aloof, had few friends, adjustable, responsible, religious, introvert.

PHYSICAL EXAMINATION:

Moderately built and nourished.

General examination – No abnormality detected.

BP – 130/80 mm Hg.

PR-88/min.

CVS – S1, S2 heard.

RS – NVBS heard.

Abdomen – Soft, nontender, No organomegaly

CNS – Clinically normal.

Bilateral fundus – Normal.

MENTAL STATUS EXAMINATION:

Patient entered the interview room with his mother. Adequately dressed. Hair kempt. Nails unclipped. Rapport was established with initial difficulty. Gaze contact was made, maintained. Not in touch with reality.

Psychomotor activity was increased.

Talk – relevant to start with, drifted on to irrelevancy. Spontaneous talk at times.

Quantum was increased; rate, tone normal and at times increased.

Emotions : Mood – elated

Affect – cheerful , appropriate, no lability

Thought – Tangentiality was present

Delusions of grandiosity, control and persecution present

Delusions of reference.

Thought broadcasting present.

Perception – Auditory Hallucinations II person in the form of male voices, talking to him. Pseudo hallucinations present.

OTHER COGNITIVE FUNCTIONS:

Oriented to time, place and person

Attention arousable, concentration well sustained.

Memory – Immediate memory impaired. Recent and remote intact.

General fund of information intact

Abstract thinking – intact

Judgement to hypothetical situation - Intact.

Insight – Denies mental illness and need for treatment. Grade I.

INVESTIGATIONS:

Haematological investigations – Within Normal Limits

Blood VDRL – Nonreactive.

ECG – Within Normal Limits

Chest X-ray – Normal.

EEG – Normal record.

PROVISIONAL DIAGNOSIS (differential diagnosis)

F25.0- Schizo affective disorder , manic type.

F 20.0 Paranoid Schizophrenia

PSYCHOLOGICAL ASSESSMENT.

Mr.J was assessed for his personality, psychopathology and diagnostic assessment with the following tests:

TESTS ADMINISTERED AND THEIR RATIONALE:

1. **Symptom Sign Inventory** to assess symptom loading on various diagnostic categories.
2. **Sentence Completion Test** semi projective test to assess the interpersonal problems, attitudes towards significant others in his life, goals and conflicts.
3. **Thematic Apperception Test**, a projective test of personality used to assess his interpersonal relationship, goals and conflicts.
4. **Brief Psychiatric Rating Scale** to rate his psychiatric symptoms
5. **Multiphasic Questionnaire** to assess his personality.
6. **Rorschach** a projective test of personality used to assess his personality structure and diagnosis.
7. **SAPS for positive symptoms**
8. **YMRS**

BEHAVIORAL OBSERVATIONS:

He is co-operative for testing but had increased talk output with paranoid and grandiose content and reaction time was quick. Comprehension was good. He was singing songs and exhibiting peculiar mannerisms.

Test Results:

He had significantly elevated scores on paranoid and schizophrenia symptoms as seen from SSI. Some of the paranoid items scored by him are others talking about him, poison him, making him ill, claiming that he has special powers and people are after him because of this. Some of the schizophrenic items scored are having auditory hallucinations, strange and peculiar experiences, being viewed odd by others, getting peculiar thoughts and feeling that something is unusual in his body.

His stories on Thematic Apperception Test are of average length containing descriptions of the individuals and their dresses. He has projected certain interpersonal frictions and hostile attitudes between the characters. He has also projected too many matters merged in a disorganised manner revealing definite thought disturbance in him. He has bizarre thought process, persecutory idea against a person he named, whom he repeatedly brought out in his themes.

Rorschach responses reveal gross thought disturbances in the content given by him since he started with one thing and kept on describing more and more without knowing where he ends up. His talk was excessive and projected more of constructive trends.

He has positive feelings towards his parents and future. He projected his family to be poor. He has faith in God and feels that he will be helped by god in all his endeavours. He is happy due to his grandiose idea but feels that he will be inheriting property because of god. He has high self esteem due to his poverty which he is going to inherit. He also projected certain sexual conflicts and preoccupations. He has disturbed thought process.

On YMRS there is definitely subjective elevation, cheerfulness, hyperactivity and at times restlessness. Speech is increased and difficult to interpret .

Functioning Level:

On global assessment of functioning test, patient falls under the level of 31-40, Some impairment in reality testing and communication, judgment, thinking and mood.

IMPRESSION :

Patient with adequate cognitive functions, with evidence of schizophrenia with affective colouring..

FINAL DIAGNOSIS:

F25.0- Schizo affective disorder , manic type

MANAGEMENT:

PHARMACOLOGICAL:

1. T. Risperidone 2 mg 1 – 0 – 1
2. T. Trihexyphenidyl 2 mg 1 – 0 – 0
3. T. Sodium valproate 200 mg 1– 1– 1

PSYCHOLOGICAL:

Psycho education to the family emphasizing the importance of drug compliance

At present he is highly disturbed. So, psychological interventions are not of much help at present. However, Supportive psychotherapy and Occupational therapy is of help to divert his talks and thoughts into useful activities.

PATIENT III

Name	:	Mr. S
Age	:	67 yrs
Sex	:	Male
Marital status	:	Married
Religion	:	Hindu
Education	:	Uneducated
Socio economic	:	LSES
Informants	:	Sons
Information	:	Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

Memory disturbance
Decrease in personal hygiene } one year, more for past 6 months
Sleep disturbance

Insidious onset, progressive course, no obvious precipitating factors

I psychiatric consultation

HISTORY OF PRESENT ILLNESS:

The patient was reported to be normal till one year back. Then, his elder son noticed that the patient repeatedly searched for certain common things in the house. He

would forget simple things in the house like the way for going to toilet. At times he also found it difficult to return to his house after going for a walk. In course of time, he was not able to identify his close relatives and called his son as his brother. He was not able to remember whether he had taken his food or not. His personal hygiene decreased gradually. He did not take bath and did not dress properly. He would pass urine inside the house itself at times. He slept for very little time and would wake up in the middle of the night and keep pacing inside the house.

PAST HISTORY:

No history of similar illness in the past.

No history of head injury, seizures or fever.

No history of Hypertension or Diabetes Mellitus.

No history of substance use.

FAMILY HISTORY:

No history of mental illness, suicide or missing members in the family.

PERSONAL HISTORY:

Early childhood history is not available.

Born of consanguinous marriage.

Married at the age of 25 years.

Living with 1 daughter and 2 sons.

PERSONALITY TRAITS:

Adjustable and Easy going.

Tolerant to criticism, responsible.

Highly religious.

He was able to do simple mathematical work and handled money and financial matters without others' help.

PHYSICAL EXAMINATION:

Thin built, not anemic, not jaundiced, no pedal edema.

Pulse – 68/min

BP – 120/80 mm Hg

CVS – S1, S2 heard.

RS – NVBS heard.

Abdomen – Soft, non tender, No organomegaly

CNS – Clinically normal.

Fundus – normal

MENTAL STATUS EXAMINATION:

General Appearance and Behavior: Conscious, ambulant, Rapport established with difficulty, not cooperative for interview, neatly dressed, no tics or mannerisms.

Psychomotor Activity – increased.

Talk – He is not communicable, answered in monosyllables after asking simple questions, that too repeatedly.

Emotions : Mood – Euthymic

Affect - Restless and irritable

Thought – No delusions.

Perception – No perceptual disturbances.

OTHER COGNITIVE FUNCTIONS:

Not oriented to time and place. Oriented to person.

Attention aroused with difficulty

Concentration impaired.

Digit Forward – 2

Digit Backward – 0

Memory – recent, remote and immediate memory are impaired.

Intelligence, abstraction and judgment could not be assessed as he could not comprehend the question.

Insight – Absent.

PROVISIONAL DIAGNOSIS:

F 00 Dementia in Alzheimer's disease

PSYCHOLOGICAL ASSESSMENT:

Mr.S, who was provisionally diagnosed as a case of dementia is taken up for psychological testing to establish the diagnosis and to assess the severity of illness.

TESTS ADMINISTERED AND THEIR RATIONALE:

1. **Mini Mental Status Examination** (MMSE) – It is a screening test to identify the organic etiology and also to assess the course of illness.
2. **Wechsler Memory Scale** – Used to assess his memory functions.
3. **Bender Gestalt test** – Used to assess the perceptual visuomotor functions
4. **Brief Psychiatric Rating Scale** – Used to assess associated psychiatric problems.
5. **Seguinform board test** – A form perception test and also used as a test of intelligence.
6. **Dementia Rating Scale** – Used to assess the severity of dementia.

BEHAVIORAL OBSERVATION:

The patient was made to sit in the chair by his sons and he frequently stood up during the interview. He was very much irritable and not cooperative for examination. Questions had to be repeated many times to get an answer.

Test results:

He obtained a very low score of 9 out of 30 in mini mental status examination showing a severe degree of impairment.

In Wechsler memory scale, he was not able to answer the questions because of

poor concentration and on repeated questioning he answered irrelevantly. He was not able to draw a figure properly in Bender Gestalt test. He simply scribbled over a paper which showed the organic nature of the disease and visuo motor disturbance.

Brief psychiatric rating scale revealed his uncooperativeness, psychomotor agitation, inappropriate affect and disorientation to time and place all of which showed an organic nature and major psychiatric symptoms such as delusions and hallucinations were not present.

He could not perform Seguin form board test and he even could not understand the way to perform the test. Dementia rating scale revealed his inability to perform household tasks, inability to find ways, inability to recall recent events, dressing without buttons, purposeless hyperactivity and diminished emotional responsiveness all of which indicates a severe degree of impairment.

SUMMARY:

There is marked impairment in his cognitive functions and visuo spatial perception. There is also deterioration in personal hygiene and personality.

FINAL DIAGNOSIS:

F00 - Dementia in Alzheimer's disease

MANAGEMENT:

PHARMACOLOGICAL:

Cholinesterase inhibitors are useful. They potentiate the cholinergic neurotransmitter.

Very low doses of antipsychotics for behavioral problems.

BEHAVIORAL:

Family counseling to provide awareness to the family members about the guarded prognosis for this patient and the importance of rehabilitation.

Relatives were advised to give an understanding atmosphere to the patient and help him not to get confused.

Importance of proper follow-up is stressed to monitor the condition of patient and to help the family members in dealing with the patient adequately.

PATIENT IV

Name	:	Mrs. J
Age	:	34 yrs
Sex	:	Female
Marital status	:	Married
Religion	:	Hindu
Education	:	B.Sc.
Socio economic	:	LSES
Informants	:	Self, mother
Information	:	Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

1. Repeated thoughts that her hands are contaminated
2. Frequent washing and cleaning
3. Fear for trivial matters

} past 20 years

Insidious onset, continuous course, I psychiatric consultation

HISTORY OF PRESENTING ILLNESS:

According to the patient, about 20 years back, she started to think that her hands were contaminated and she started washing her hands very frequently. She started to worry about her routines and started to wash repeatedly all her households like utensils,

clothes, floor, household items and used to take bath for long hours to keep herself clean. Though she preferred to keep herself clean, she excessively indulged in these acts only in recent times. The thoughts of cleanliness occurred repeatedly as intrusive ones in her mind and got partial satisfaction only after performing these acts. This also resulted in disturbance in her work time, resulting in absenteeism and she was left feeling helpless over this issue.

She kept doubting about matters like whether she had locked the door, switched off the lights and would keep checking repeatedly even though she felt it was excessive.

She also had disturbed sleep at times pondering over these issues. She felt low over this problem and consulted IMH OP, and was put on Clomipramine and Amitryptiline, following which she showed improvement.

No h/o hearing voices, suspiciousness

No h/o tall claims

No h/o head trauma or seizures

PAST HISTORY:

No significant medical or psychiatric illness.

FAMILY HISTORY:

Born of non consanguinous marriage

History of similar illness in her paternal uncle

She is the eldest of 3 children.

No significant family history

PERSONAL HISTORY:

Birth and milestones normal

Educated and employed.

Menarche by 13 years. Regular menstrual periods.

Married at 20 years of age. Has 3 children, who are healthy..

PERSONALITY TRAITS:

Extrovert, had many friends, religious, perfectionist, meticulous in her activities, enjoyed gardening and reading books.

PHYSICAL EXAMINATION:

Alert , ambulant

BP – 120/70 mm Hg.

PR-80/min.

CVS – S1, S2 heard.

RS – NVBS heard.

Abdomen – Soft, non tender, No organomegaly

CNS – Clinically normal.

Fundus – normal

MENTAL STATUS EXAMINATION:

General Appearance and Behavior: alert , in touch with surroundings, well kempt, dressed adequately. Rapport was established. Gaze contact made and maintained.

Psychomotor activity – within normal limits

Talk – relevant and coherent. Quantum, rate and tone- normal. Reaction time normal.

Emotions : Mood – Anxious

Affect – Anxious, appropriate. No lability.

Thought- Form, stream- normal

Content – No delusions, no referential ideas

Ideas of helplessness

Possession – Obsessions and washing compulsions

OTHER COGNITIVE FUNCTIONS:

Oriented to time, place and person

Attention aroused, Concentration well sustained

Digit Forward – 5

Digit Backward – 4

Memory – immediate, recent and remote – intact

General fund of information – adequate

Average intelligence

Abstract thinking intact.

Judgement to test situation intact

Insight: Grade VI – True emotional insight.

DIAGNOSTIC FORMULATION

34 years old Female presenting with complaints of repeated thoughts that her hands are

contaminated, frequent washing and cleaning, apprehension and unpleasant repeated intrusive thoughts encompassing her occupation, MSE showed anxious mood with obsessions and compulsions.

PROVISIONAL DIAGNOSIS

F 42.2 Obsessive Compulsive Disorder, Mixed obsessional thoughts and acts.

PSYCHOLOGICAL ASSESSMENT:

Mrs. J , provisionally diagnosed as a case of OCD is taken up for psychological assessment to assess her symptoms patterns, severity of illness and for personality.

Tests Administered and Their Rationale

1. **Eysenck Personality Questionnaire** was used to assess the different dimensions of her personality.
2. **Sentence Completion Test** was used to elaborate on her attitude towards family, parents, and his interpersonal relationships.
3. **Thematic Apperception Test**, a projective test of personality used to assess her interpersonal relationship, goals and conflicts.
4. **Rorschach test**, a projective test of personality used to assess her personality structure and diagnosis.
5. **Hamilton Anxiety Scale** is used to assess the severity of anxiety
6. **Yale Brown Obsessive Compulsive Scale**: It is used to rate the severity of obsessive and compulsive symptoms.

7. **Hamilton Rating Scale for Depression** used to estimate the level of depression

BEHAVIORAL OBSERVATIONS DURING TESTING:

Rapport could be established easily. She came out with her problems by herself.

She was cooperative and regular to the sessions.

Test results:

Eysenck's Personality Questionnaire: Her scores indicate severe degree of neuroticism with low psychoticism and moderate extroversion.

Sentence Completion Test – She has positive feelings towards friends, superiors, teachers, marriage and women in general. She has negative feelings towards her father. She showed feelings of inferiority and high sensitivity, longing for affection from others. She is apprehensive about minor conflicts.

Thematic Apperception Test – Her stories are productive, imaginative and projective of her childhood experience as a neglected child. Her parents had highly conflicting attachments which had resulted in her fears and conflicts about marriage and sex. She is also highly neurotic with fears of darkness and loneliness.

Rorschach test – Her responses reveal that she is highly imaginative which at times leads to unwanted thoughts, preoccupations and emotional reactions. She has highly disturbed personality with highly critical attitude which even amounts to paranoid ideations. She has adequate ego strength inspite of neurotic fears which favours the receptivity of psychotherapeutic interventions.

Rating Scales – reveal mixed symptoms of obsessions and compulsions with features of anxiety and a certain amount of depression due to life stressors.

SUMMARY:

She scored high on various neurotic dimensions on personality indicating that she is highly neurotic in her thoughts, feelings and reactions to the environment with which we can diagnose her as a case of mixed neurosis with obsessive symptoms.

FINAL DIAGNOSIS :

F 42.2 Obsessive Compulsive Disorder, Mixed obsessional thoughts and acts.

MANAGEMENT:

PHARMACOLOGICAL:

T. Clomipramine 25 mg 1-0-1

T. Clonazepam 0.5 mg 0-0-1

PSYCHOTHERAPY:

Cognitive Behavioral Therapy to change and modify irrational thoughts.

Exposure and response prevention to manage the compulsions

Thought Stopping to manage the obsessions

As she has high dependency needs and insecurity, she was treated with supportive psychotherapy. Behavior counseling is also undertaken. Family therapy is of utmost importance and occupational rehabilitation is also a part of therapy.

Patient V

Name : Ms S

Age : 15 yrs

Sex : female

Education : nil

Socio-economic status : MSES

Back ground : Urban

Informant : Mother

Information : reliable, adequate and consistent

REASONS FOR CONSULTATION

Delayed developmental milestones

Aggressive towards family member } since childhood

Disruptive behaviour

HISTORY OF PRESENTING ILLNESS:

Patient was born out of non consanguinous marriage, full term normal delivery. Mother was 24 yrs and fathers age was 28 yrs. No history of any drug intake, fever or exanthematous eruptions in the ante natal period. No antenatal checkup was done. No history of radiation, injury, malnutrition, or vaginal bleeding. Delivery was conducted by local dhai, the baby cried soon after birth and was breast fed after a short while. No h/o neonatal seizures or difficulty in feeding. No h/o of jaundice, breast fed up to 1 year, and there were no weaning difficulties.

Milestones

Motor	Head control	8 months
	Sitting with support	2 years
	Sitting without support	2 yrs 4 months
	Standing without support	3 yrs 6 months
	Walking on her own	4 years
Language	Babbling	
	1 word	4 years
	2-3 words	8 years
Personal and social behavior	Bowel control	8 years
	Bladder control	Yet to attain bladder control

PRESENT FUNCTIONING LEVEL

The patient is not able to take care of her own daily chores like bathing, dressing, eating without assistance etc. She at times passes urine in her clothes itself, does not maintain personal hygiene during menstruation. She has been pinching and slapping her mother. Her stubbornness and adamant behavior have increased during the last 1 year.

PSYCHIATRIC HISTORY

Nil significant

FAMILY HISTORY

2nd of 2 children

No h/o seizures, MR in family

Taken care of by her parents.

PHYSICAL EXAMINATION:

General condition fair

Low set ears, Squint +

Pulse – 80/min

BP – 110/76 mm Hg

CVS – S1, S2 heard

RS – NVBS heard

Abdomen – soft, nontender

CNS – No FND, No neurocutaneous markers

Fundus – NAD

Mental Status Examination:

Anxious, Oriented, In touch with surroundings

Dressed fairly, well kempt

Unsteadiness of gait +

Drooling of saliva +

Poor gaze contact

Rapport was difficult to establish

She is fidgety and restless.

She smiled inappropriately and tried to pinch her mother in between

Increased psychomotor activity

Speech – utters 2 or 3 words

Silly affect

No perceptual abnormality

Cognitive Functions:

Attention aroused but not sustained

Oriented to place, person

PROVISIONAL DIAGNOSIS

F 72 Severe Mental Retardation

PSYCHOLOGICAL ASSESSMENT

Ms. S is assessed for her intellectual functions and social function with the following tests.

1. **Seguin Form Board test –** It is a test of form perception and can be used as a test of intelligence to test the baseline intellectual abilities.
2. **Vineland Social Maturity scale** – Used to assess her social maturity level
3. **Behavioral Rating Scale**

BEHAVIORAL OBSERVATION:

She was not very cooperative for testing and had less interest in test situation. Patient was not very attentive and was not able to concentrate for most of the tests. Her psychomotor activity was raised and she was fidgety.

TEST RESULTS:

Her gestalt functions and concept formation of size, shape and form were poor. She was able to carry out simple commands with difficult. Her digit span score was 2. Her functioning is below 3 – 5 years as seen from Seguin Form Board test.

Her social functioning is about 3 years as rated from Vineland Social Maturity scale. Her mother reports that she is functioning at the age of 3 years in self help, eating, dressing, occupation and at the level of 2 years in communication, locomotion and socialization.

On behavior rating scale she scored highly on many items in violent behavior, destructive behavior and rebellion and hyperactive behavior.

SUMMARY

She has poor intellectual functioning. Her IQ of 16 places her in profound mental retardation with behavioural problems. She needs help from family members to take adequate care of her.

FINAL DIAGNOSIS:

F 73 PROFOUND MENTAL RETARDATION

MANAGEMENT:

1) Behavior modification by shaping, prompting

2) Rehabilitation and special school training. The special school training should help her to acquire basic life skills and possibly some amount of independence in day to day chores like brushing, putting clothes etc

3) Pharmacotherapy—is reserved only in case of severe aggression, violence etc.

Carbamazepine would be considered if required.